FOR BHF USE

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0047175

Facility Name: MIDWAY NEUROLOGICAL/REHAB CENTER

Address: 8540 SOUTH HARLEM AVENUE (Number) BRIDGEVIEW (City) 60455 (Zip Code)

County: COOK

Telephone Number: (708) 598-2605 **Fax #** (708) 598-5671

HFS ID Number: 202040687001

Date of Initial License for Current Owners: 4/1/05

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DANIEL S. GAAFAR **Telephone Number:** (317) 237-5500

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 4/1/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MOISHE GUBIN
(Title) TREASURER

Paid Preparer

(Signed) SEE ACCOUNTANTS' REPORT ATTACHED (Date)
(Print Name and Title) DANIEL S. GAAFAR, PARTNER
(Firm Name & Address) BRADLEY & ASSOCIATES, INC., 201 S. CAPITOL AVE., STE 910, INDIANAPOLIS, IN 46225
(Telephone) (317) 237-5500 Fax # (317) 237-5503

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	404	Skilled (SNF)	404	111,100	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	404	TOTALS	404	111,100	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	67,258	1,064	5,721	74,043	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	67,258	1,064	5,721	74,043	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.65%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/1/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/1/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 404 and days of care provided 4,662

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CEN # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	292,169	309,365		601,534		601,534	(20)	601,514			1
2	Food Purchase											2
3	Housekeeping	1,685	136	360,427	362,248		362,248		362,248			3
4	Laundry	1,156	(9)		1,147		1,147		1,147			4
5	Heat and Other Utilities			264,596	264,596		264,596		264,596			5
6	Maintenance	81,974	24,380	59,005	165,359		165,359	(808)	164,551			6
7	Other (specify):*											7
8	**TOTAL General Services**	376,984	333,872	684,028	1,394,884		1,394,884	(828)	1,394,056			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,051,985	116,058	15,613	2,183,656	2,250	2,185,906		2,185,906			10
10a	Therapy			290,168	290,168		290,168		290,168			10a
11	Activities	108,314	19,238		127,552		127,552		127,552			11
12	Social Services	137,790	318	2,558	140,666		140,666		140,666			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,298,089	135,614	308,339	2,742,042	2,250	2,744,292		2,744,292			16
	C. General Administration											
17	Administrative	96,244			96,244		96,244		96,244			17
18	Directors Fees											18
19	Professional Services			63,663	63,663		63,663	(51,101)	12,562			19
20	Dues, Fees, Subscriptions & Promotions			3,168	3,168		3,168	47	3,215			20
21	Clerical & General Office Expenses	307,238	50,891	1,912	360,041		360,041	(3,988)	356,053			21
22	Employee Benefits & Payroll Taxes			477,790	477,790		477,790	19,815	497,605			22
23	Inservice Training & Education											23
24	Travel and Seminar			22,517	22,517		22,517	80	22,597			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			212,492	212,492		212,492		212,492			26
27	Other (specify):*											27
28	**TOTAL General Administration**	403,482	50,891	781,542	1,235,915		1,235,915	(35,147)	1,200,768			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,078,555	520,377	1,773,909	5,372,841	2,250	5,375,091	(35,975)	5,339,116			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER #0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			31,684	31,684		31,684	(7,921)	23,763			30
31	Amortization of Pre-Op. & Org.			6,507	6,507		6,507	(32)	6,475			31
32	Interest			69,950	69,950		69,950		69,950			32
33	Real Estate Taxes			337,500	337,500		337,500		337,500			33
34	Rent-Facility & Grounds			1,327,500	1,327,500		1,327,500		1,327,500			34
35	Rent-Equipment & Vehicles			185	185		185		185			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,773,326	1,773,326		1,773,326	(7,953)	1,765,373			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		198,782		198,782	(2,250)	196,532		196,532			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			166,650	166,650		166,650		166,650			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		198,782	166,650	365,432	(2,250)	363,182		363,182			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,078,555	719,159	3,713,885	7,511,599		7,511,599	(43,928)	7,467,671			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(20)	1		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(50)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,037)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (4,107)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(31,060)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (31,060)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (35,167)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

MIDWAY NEUROLOGICAL/REHAB CENTER

ID# 0047175

Report Period Beginning: 4/1/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEPRECIATION EXPENSE	$ (7,921)	30	1
2	AMORTIZATION EXPENSE	(32)	31	2
3	VENDING INCOME	(808)	6	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,761)		49

MIDWAY NEUROLOGICAL/REHAB CENTER
EXPENSE RECLASSIFICATIONS
12/31/05

SCHEDULE	LINE #	COL #	DESCRIPTION	INCREASE (DECREASE)
V	10	5	PHARMACY CONSULTANT	2,250
V	39	5	PHARMACY CONSULTANT	(2,250)

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 **Report Period Beginning:** 4/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(20)	0	0	0	0	0	0	0	0	0	0	(20)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(808)	0	0	0	0	0	0	0	0	0	0	(808)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(828)	0	0	0	0	0	0	0	0	0	0	(828)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(51,101)	0	0	0	0	0	0	0	0	0	(51,101)	19
20	Fees, Subscriptions & Promotions	0	47	0	0	0	0	0	0	0	0	0	47	20
21	Clerical & General Office Expenses	(4,087)	99	0	0	0	0	0	0	0	0	0	(3,988)	21
22	Employee Benefits & Payroll Taxes	0	19,815	0	0	0	0	0	0	0	0	0	19,815	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	80	0	0	0	0	0	0	0	0	0	80	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(4,087)	(31,060)	0	0	0	0	0	0	0	0	0	(35,147)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,915)	(31,060)	0	0	0	0	0	0	0	0	0	(35,975)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 **Report Period Beginning:** 4/1/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,921)	0	0	0	0	0	0	0	0	0	0	(7,921)	30
31	Amortization of Pre-Op. & Org.	(32)	0	0	0	0	0	0	0	0	0	0	(32)	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,953)	0	0	0	0	0	0	0	0	0	0	(7,953)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(12,868)	(31,060)	0	0	0	0	0	0	0	0	0	(43,928)	45

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHMENT #1				SEE ATTACHMENT #1		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	PROFESSIONAL FEES	$ 52,083	NEW YORK BOYS MANAGEMENT	46.25%	$	$ (52,083)	1
2	V	19	ACCOUNTING & PROF. FEES				982	982	2
3	V	20	LICENSES & PERMITS				47	47	3
4	V	21	BANK SERVICE CHG, MISC.				99	99	4
5	V	22	PENSION				19,815	19,815	5
6	V	24	TRAVEL & AUTO EXP.				80	80	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 52,083			$ 21,023	$ * (31,060)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

ATTACHMENT #1

OWNERS

NAME	OWNERSHIP %
MICHAEL BLISKO	23.125%
MOISHE GUBIN	23.125%
AARON TOPPER	17.325%
MARTY LOEB	5.000%
JOSEPH BLISKO	5.000%
TEVI MINDICK	5.000%
HOWARD N. SUSS	3.925%
A&F GENERAL PARTNERSHIP	17.500%
	100.000%

OTHER RELATED BUSINESS ENTITIES

NAME	CITY	TYPE OF BUSINESS
NEW YORK BOYS MANAGEMENT	CROWN POINT, IN	MANAGEMENT CO.

NOTE: NEW YORK BOYS MANAGEMENT IS OWNED BY MOISHE GUBIN AND MICHAEL BLISKO.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CEN # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	AARON TOPPER	ADMINISTRATOR	ADMINISTRATIC	17.33		40	100.00	SALARY	$ 96,244	17-1	1
2	MICHAEL BLISKO	DIR. OF OPERATIO	ADMINISTRATIC	23.13		12	30.00	SALARY	39,891	21-1	2
3	MOISHE GUBIN	TREASURER	ADMINISTRATIC	23.13		20	50.00	SALARY	41,362	21-1	3
4	MARTY LOEB	CONTROLLER	ADMINISTRATIC	5.00		16	40.00	SALARY	13,750	21-1	4
5	JOSEPH BLISKO			5.00							5
6	TEVI MINDICK			5.00							6
7	HOWARD N. SUSS			3.93							7
8	A&F GENERAL PARTNERSHIP			17.50							8
9											9
10											10
11											11
12											12
13								TOTAL	$ 191,247		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CEN # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bank Leumi USA		X	Working Capital	None	1/24/05	2,500,000	1,000,000	4/3/06	8.5000	69,950	6
7												7
8												8
9	TOTAL Facility Related						$ 2,500,000	$ 1,000,000			$ 69,950	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,500,000	$ 1,000,000			$ 69,950	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	337,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	337,500	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

$37,500 payable each month to lessor for real estate taxes

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MIDWAY NEUROLOGICAL/REHAB CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0047175

CONTACT PERSON REGARDING THIS REPORT DANIEL S. GAAFAR

TELEPHONE (317) 237-5500 FAX #: (317) 237-5503

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	18-36-403-013-0000	NURSING HOME	$ N/A	$ N/A
2.	Current owners took over nursing home 4/1/05		$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 112,340 B. General Construction Type: Exterior BRICK Frame CONCRETE/STEEL Number of Stories 5

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 43,170
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 6,475
4. Dates Incurred: Various - April 2005 through December 2005

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sign			2005	6,000	300	15	300		400	9
10	Air Conditioner			2005	38,280	1,910	15	1,910		2,552	10
11	Home Depot			2005	7,041	352	15	352		469	11
12	Time Clock			2005	5,651	283	15	283		377	12
13	Elevator Items			2005	17,500	875	15	875		1,167	13
14	Elevator Items			2005	1,761	88	15	88		117	14
15	Ice Machine			2005	5,790	290	15	290		386	15
16	Wanesguard Security Camera			2005	23,000	1,150	15	1,150		1,533	16
17	Wanesguard Security Camera			2005	6,000	300	15	300		400	17
18	Wanesguard Security Camera			2005	673	34	15	34		45	18
19	Wanesguard Security Camera			2005	5,625	281	15	281		375	19
20	Tiles			2005	4,461	223	15	223		297	20
21	Tiles			2005	246	12	15	12		16	21
22	Tiles			2005	733	37	15	37		49	22
23	HVAC			2005	4,251	213	15	213		283	23
24	HVAC			2005	3,653	183	15	183		244	24
25	Boilers			2005	7,850	393	15	393		523	25
26	Roof Repairs			2005	1,500	75	15	75		100	26
27	Lights			2005	6,650	333	15	333		443	27
28	Tiles			2005	1,113	56	15	56		74	28
29	Renovation pmts. to contractor for window			2005	179,615	8,981	15	8,981		11,974	29
30	treatments, built-in dressers, wallpaper, tiling, linens,										30
31	curtains, paint, and artwork										31
32	Labor for renovtions			2005	1,350	68	15	68		91	32
33	Labor for renovtions			2005	1,350	68	15	68		91	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 330,093	$ 16,505		$ 16,505	$	$ 22,006	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$	$	$	$		$	71
72	Current Year Purchases	48,389	7,258	7,258		5	9,678	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 48,389	$ 7,258	$ 7,258	$		$ 9,678	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	N/A			$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 378,482	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 23,763	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 23,763	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 31,684	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: METROPOLITAN REAL ESTATE PARTNERSHIP
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		404	4/1/05	$ 1,327,500	4		3
4	Additions							4
5								5
6								6
7	TOTAL		404		$ 1,327,500 **			7

10. Effective dates of current rental agreement:
    Beginning 4/1/05
    Ending 11/30/08

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/2006	$ 1,770,000
13.	12/2007	$ 1,770,000
14.	12/2008	$ 1,622,500

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$ 0	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$		$ 111,530	$		$ 111,530	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs			94,680			94,680	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs			83,958			83,958	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				192,562		192,562	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Radiology & Lab	39-2					6,220		6,220	13
14	TOTAL			$		$ 290,168	$ 198,782		$ 488,950	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER **#** 0047175 **Report Period Beginning:** 4/1/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 615,961	$	1
2	Cash-Patient Deposits	3,907		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,762,470		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	219,095		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,601,433	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	330,094		15
16	Equipment, at Historical Cost	48,389		16
17	Accumulated Depreciation (book methods)	(31,684)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	43,170		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(6,507)		20
21	Restricted Funds			21
22	Other Long-Term Assets (spc **Security Deposit**	32,531		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 415,993	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,017,426	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 703,250	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	289,381		30
31	Accrued Taxes Payable (excluding real estate taxes)	(3,197)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 989,434	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,000,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,000,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,989,434	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,027,992	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,017,426	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER **#** 0047175 **Report Period Beginning:** 4/1/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 180,895	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 180,895	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	847,096	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 847,097	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,027,992	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,764,585	1
2	Discounts and Allowances for all Levels	(157,744)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,606,841	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	564,442	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 564,442	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	164,984	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	5,963	19
20	Radiology and X-Ray	1,185	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 172,132	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	8,362	27
28	Vending Income	808	28
28a	Miscellaneous Revenue	6,110	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,280	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,358,695	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,394,884	31
32	Health Care	2,742,042	32
33	General Administration	1,235,915	33
	B. Capital Expense		
34	Ownership	1,773,326	34
	C. Ancillary Expense		
35	Special Cost Centers	198,782	35
36	Provider Participation Fee	166,650	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,511,599	40
41	**Income before Income Taxes (line 30 minus line 40)****	847,096	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 847,096	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Attachment #2

Net income does not agree with the 12/31/05 tax return as the cost report was filed for 4/1/05-12/31/05 and the tax return was filed for 1/1/05-12/31/05.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,752	1,863	$ 75,437	$ 40.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	13,887	11,325	300,517	26.54	3
4	Licensed Practical Nurses	43,916	38,993	929,956	23.85	4
5	CNAs & Orderlies	82,198	72,731	717,939	9.87	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	929	896	6,166	6.88	8
9	Activity Director	9,954	9,802	108,314	11.05	9
10	Activity Assistants					10
11	Social Service Workers	14,386	13,117	190,344	14.51	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	35,748	32,177	292,170	9.08	15
16	Dishwashers					16
17	Maintenance Workers	6,269	5,049	81,974	16.24	17
18	Housekeepers	7,321	234	1,685	7.20	18
19	Laundry	4,268	153	1,156	7.56	19
20	Administrator	1,636	3,087	96,244	31.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	17,965	18,757	254,683	13.58	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,114	2,069	21,970	10.62	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	242,343	210,253	$ 3,078,555 *	$ 14.64	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant	23	813	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	73	2,558	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	96	$ 3,371		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	296	$ 14,800	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	296	$ 14,800		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
AARON TOPPER	ADMIN	17.325	$ 96,244
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,244

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
NEW YORK BOYS MGMT.	MGMT. CO.	52,084
FINKLE, MARTWICK & COLSON	LEGAL	5,140
1ST REAL ESTATE	APPRAISAL	3,250
MISCELLANEOUS	MISCELLANEOUS	1,699
ABRAHAM GUTNICKI	LEGAL	1,490
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 63,663

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,152
Unemployment Compensation Insurance	50,527
FICA Taxes	216,812
Employee Health Insurance	128,480
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
UNIFORMS	10,819
PENSION	19,815
TOTAL (agree to Schedule V, line 22, col.8)	$ 497,605

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 687
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
ILLINOIS SECRETARY OF STATE	705
VILLAGE OF BRIDGEVIEW	649
COOK COUNTY COLLECTOR	75
BRIDGEVIEW CHAMBER OF COMMERC	559
LICENSE PLATE & CLEO LAB	128
PLOUGHS COUNCIL AGING, DEPT. OF P	413
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,215

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
AUTO ALLOWANCE	16,060
MILEAGE	3,782
Seminar Expense	
ILLINOIS COUNCIL	2,198
HIN SEMINAR	299
MEDICAL CONSULT NETWORK	258
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 22,597

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number MIDWAY NEUROLOGICAL/REHAB CENTER # 0047175 Report Period Beginning: 4/1/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **16,805** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **N/A** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? **X** YES _____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **166,650**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **N/A**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees